Int. j. adv. multidisc. res. stud. 2024; 4(5):691-697

Received: 10-08-2024
Accepted: 20-09-2024

International Journal of Advanced Multidisciplinary Research and Studies

ISSN: 2583-049X

Harmful Traditional Practices Affecting the Under-Five Years Children and Associated Factors in Sokoto, State, Nigeria

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DOI: https://doi.org/10.62225/2583049X.2024.4.5.3311
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Abstract

Introduction

Harmful traditional practices violate and negatively affect the physical, psychological well-being and right of women and children. Nigeria has the third highest absolute number of women and girls who have undergone Female Genital Mutilation (FGM) worldwide.

Aims

To assess the harmful traditional practices on the under-five years children and associated factors in Sokoto, State, Nigeria.

Methods

A community based cross sectional study that was conducted in Sokoto State, Nigeria on 320 mothers of under-five year children from 1st January-31st March 2021. The study participants were selected using multi stage sampling method, after proportionate allocation of sample size, systematic random sampling method was used to get the study participants. A structured questionnaire was used to collect information on harmful traditional practices from the mothers of the eligible children. Data was analysed using SPSS version 22.

Results

The mean age of the children was 22.5 ± 17.7 months, there were 199(62.2%) males and 121(37.8%) females, and male to female ratio was 1.6:1. Eighty (25.0%) of the under five-year children were circumcised by traditional healers, 189(59.1%) had traditional uvulectomy, 86(28.9%) had female genital mutilation, while 11(3.4%) had scarification marks. The respondent's educational status (p = 0.008) and (p = 0.001) were factors associated with the practice of FGM and circumcision respectively.

Conclusion

Harmful traditional practices are still prevalent in Sokoto. Government at all levels should embark on awareness creation programs on the dangers of these harmful traditional practices through mass media, schools, traditional leaders and religious places. Child protection laws should be implemented to curtail these harmful practices.

Keywords: Harmful Traditional Practices, Under-Five Years, Sokoto

Introduction

Traditional medicine is the sum of total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation whether verbally or in writing (Gebrekirstos *et al*, 2014) [12]. Different social groups all over the world have specific practices and beliefs which often have strong cultural basis and these practices can have positive or negative effects on an individual (Gabriel-Job *et al*, 2022), not all traditional practices are detrimental, some have benefits such as extended family system, prolonged breastfeeding, respect for elders (Alabi, 1990) [3] and promoting social cohesion and unity, while others erode the physical and psychological health and integrity of individuals, particularly that of children and women (Alene G &Edris, 2002) [5]. All violations of children's right can legitimately be described as harmful practices however, if done according to certain traditions are termed harmful traditional practices (Gabriel-Job *et al*, 2022). Harmful traditional practices (HTPs) encompasses a range of abuse which results in physical and psychological harm, disability and even death for significant numbers of women and children (Omoniyi, 2020) [13]. Harmful traditional practices occur across all gender, social class and are not unique to a particular tribe or religion (Epundu *et al*, 2018) [9]. It primarily affects children and women (Gebrekirstos *et al*, 2014) [12]. Children are usually very vulnerable to such abuses by the

traditional healers since consent is only obtained from the parents who believe in the benefits derived from the procedure (Adamu *et al*, 2021). The type of HTP carried out varies from infanthood to young children, adolescents and even at the time of marriage (Gabriel-Job *et al*, 2022).

These harmful practices constitute a public health concern considering their broad spectrum and wide-spread use across all cultures, religious beliefs, socioeconomic and educational status among the users, as well as their complications and adverse effects on the children which may be immediate or long term (Chapp-Jumbo, 2008) [8]. While their utilization vary from culture and locality there are so many harmful practices worldwide, ranging from uvula cutting and milk teeth extraction, forced feeding, nutritional taboos (Gebrekirstos *et al*, 2014) [12], children are restricted from certain nutritious diet like eating egg, that it will make a child to steal if accustomed to eating eggs (Ekwochi, 2016) [14], which put the child at risk of under-nutrition, Keeping babies from exposure to sunlight, feeding newborn babies with fresh butter, delayed breastfeeding initiation to newborns, application of animal dung and other unhygienic substances on umbilical stumps of neonates, use of enema on sick child and application of palm kernel oil on a febrile child (Edet, 2023) [15] and not giving colostrum to newborns due to misconception that it is a dirty milk (Mose *et al*, 2021) [16]. Other HTPs are child marriage, female Infanticide, shaking baby syndrome, breast ironing, son preference and traditional male circumcision (Omoniyi, 2020) [13]. These HTPs also include various crude traditional surgical procedures such as female genital mutilation, milk teeth extraction, blood-letting, traditional uvulectomy, scarification marks, ear piercing and eye brows incisions (Alene G & Edris, 2002) [5]. Female Genital Mutilation (FGM) is a traditional operation that involves cutting away parts of the female external genitalia or other injuries to the female genitalia for cultural reasons (Epundu *et al*, 2018) [9]. Global estimates show that about 140 million girls and women have been circumcised, with as many as 3 million girls at risk of undergoing FGM every year (Epundu *et al*, 2018) [9]. A global review of FGM shows that FGM is known to be practiced in one form or another in at-least 26 African countries as well as in some Arab and Asian countries and among immigrant communities in Europe, Australia, and the United States (Alene & Edris, 2002) [5]. Nigeria has the third highest absolute number of women and girls who have undergone FGM worldwide (Morlighem & Visée). A survey in Nigeria reveals that Nigeria has a national prevalence of 25% (National Population Commission, 2014). Female Genital Mutilation is more prevalent in the southern part of Nigeria than the Northern part (Epundu, 2018) [9]. The rationale behind FGM is to maintain the moral behavior of women and girls in the society (McCauley & Broek, 2019) [18], females that are not circumcised are believed to have a strong desire for sex and it is believed if not circumcised may indulge in extramarital sex to satisfy their needs and preserve virginity (Garba *et al*, 2012) [11], in some areas virginity is highly valued, infibulation is performed to make a female totally handicapped for premarital sex (Epundu, 2018) [9]. Traditional uvulectomy is a common practice in areas of the world especially in the Middle East (Egypt, Saudi Arabia, Israel, Lebanon and Yemen), western Africa (Sierra Leone, Sudan, Mali and Nigeria), East Africa (Eritrea, Ethiopia, Kenya and Tanzania), Central Africa (Cameroun and Chad), and Northern Africa (Sudan and Morocco) (Ravesloot and De Vries, 2011) [19]. The traditional uvulectomist inherit the skills from their predecessors with no formal medical training (Adamu *et al*, 2021). In Sub-Saharan Africa, the practice of traditional uvulectomy is very common among children and the benefits perceived to be derived from the belief that uvula leads to various childhood diseases (Isa *et al*., 2011) [20]. The practice of traditional uvulectomy falls into one of two categories: Ritual uvulectomy and therapeutic uvulectomy (Abdullahi & Amutta, 2016). Ritual uvulectomy is performed routinely, usually at birth often the procedure itself is part of a naming ceremony (7th day) (Alebachew *et al*, 2019) [4]. Although various reasons may be ascribed to it, the primary reason is tradition (Ajibade et al, 2013), the reasons offered by the caregivers are: Because it was a ritual tradition that was performed on their parents and on their grandparents (Hunter, 1995), it facilitates breastfeeding and speech, it ensures better health throughout life, that it decreases thirst, it prevents infants from choking and prevents infant diarrhea (Adamu *et al*, 2021). Therapeutic traditional uvula cutting is performed on children to treat sore throat (Olaosun *et al*., 2011), failure to thrive, frequent fever, rejection of feeds, vomiting, cough, diarrhoea and abdominal pain (Isa *et al*, 2011) [20]. Even though the care givers perceived these traditional practices as remedy for most ailments they are associated with so many complications such as haemorrhage, anaemia, septicaemia, tetanus, Human Immunodeficiency Virus, hepatitis B and C infection, aspiration of cut uvula into the lungs and chest infection, and tetanus (Adamu *et al*, 2021). Other late complications of HTPs particularly FGM includes infertility, chronic pelvic pain, painful menstruation, cyst formation and vesico-vaginal fistulae, dyspareunia leading to poor quality of sexual life, mortality, psychological trauma and financial burden of managing complications on the family and health care system, prolonged labour and babies of mothers that had FGM are at risk birth asphyxia (Epundu, 2018) [9]. The prevalence and effects of harmful traditional practices especially in sub-Saharan African countries remains a public health concern (Jimoh *et al*, 2018) [22]. Despite numerous efforts by various NGOs such as UNICEF, UNFPA and WHO in Nigeria to eliminate harmful traditional practices in Nigeria affecting women and children, studies have shown that these practices are still ongoing (Jimoh *et al*, 2018; Isa *et al*, 2013; Edet *et al*, 2023) [22, 20, 15]. In some communities these harmful traditional practices are deep rooted and are taken as normal practices and therefore not recognized as harmful (Jimoh *et al*, 2018) [22]. This study therefore aimed to assess the prevalence of practice of some harmful traditional practices on the under-five year children and associated factors in Sokoto, State, Nigeria. The findings from this study will provide relevant data on the extent of these HTPs that will form the rationale for campaign against harmful traditional practices on children.

Methodology

Background Information on the Study Area

The study was conducted in Sokoto state, Nigeria. It is one of the six states of the North-western zone of the country and is located in the extreme part of the North-western zone of the country. The state is divided in to 3 senatorial zones, namely: North, West and East zones. It has a total of 23 Local government Areas (LGAs), 5 of which are urban and

18 are rural and a total of 244 political wards. The study was carried out in two selected urban LGAs and two selected rural LGAs.

Study Design

This was a cross sectional community based study that was done from 1st January -31st March 2021.

Study Population

The study population comprised mothers and their children aged 0 to 5 years in Sokoto state.

Sample Size Determination

Minimum sample size was determined using the formula (Araoye, 2004):n = z2 pq/d2, Where n= minimum sample size required z= standard normal deviate corresponding to 95% confidence interval level= 1.96, q= complimentary probability of p, d= degree of accuracy desired, set at = 0.05, p= proportion of factor under study i.e. proportion of mothers of under five children who practiced FGM as observed from a previous study = 16.0% (Briggs *et al*, 2002) [7]. Allowing for 95% response rate, the minimum sample size (ns) was given as: ns = n/0.95 =304/0.95 = 320. Therefore, the minimum sample size required was 320.

Sampling Technique

Multistage sampling technique was used:

Sokoto state has 5 urban LGAs and 18 LGAs in the rural areas.

Stage I: Selection of LGAs

Two LGAs were selected each from the 5 urban LGAs and from the 18 rural LGAs using simple random sampling by balloting (Sokoto North and South were selected each from the 5 urban LGAs and Bodinga and DangeShuni from the 18 rural LGAs using simple random sampling by balloting).

Stage 2: Selection of wards Two wards were selected from each of the urban and rural LGAs using simple random sampling by balloting (The two wards selected from the Urban LGAs were Magajin Rafi and GidanIgwai from Sokoto North LGA, while from Sokoto South LGA, Sarkin Adar B and Gagi A wards were selected, from the rural LGAs, the two wards selected were Badau and Bodinga all from Bodinga LGA and Tuntuben Shuni and Rikina from Dange Shuni LGA.

Stage 3: Selection of settlements, list of the settlements in the selected wards was obtained from the respective LGAs authorities. One settlement was elected from each of the selected wards in the urban and rural LGAs respectively using simple random sampling by balloting, making a total of eight settlements.

The settlements selected included Badau settlement (Badau Ward); Shiyar Sarki B settlement (Bodinga Ward); Rumbukawa settlement (Tuntuben Shuni ward); Rikina A settlement (Rikina ward); Madunka settlement (Magajin Rafi Ward); Runjin Sambo settlement (Gidan Igwai Ward); Gidan Kannawa settlement (Sarkin Adar B ward) and Tamaje settlement (Gagi A ward).

Stage 4: Selection of household

Systematic sampling method was done to select the houses to be included in the study. The households were numbered in the settlements to get the sampling frame (from 1to N), based on the allocated sample n) in each settlement, the sampling interval K was calculated as follows N/n, then a number was randomly selected between I and K, every Kth unit was enrolled in the study, from the central land mark such as village head house, market, mosque or school, a direction was chosen randomly, household were selected alongside the direction up to the edge of the settlement in a clockwise direction, and respondents were interviewed in their households until the required sample size was achieved, if no one is found present in a household, the next house was sampled instead.

Stage 5: Selection of the eligible study subjects, list of eligible study subjects in each of the selected settlements was obtained from the respective LGAs authorities and proportionate allocation was done based on the number of eligible study subjects in each settlement. In each of the selected houses, one eligible mother child pair was selected using simple random sampling by balloting. In a house where there is more than one eligible study subject (more than 2 mothers of under-five (U5) children or more than 2 under five children) simple random sampling method using balloting was used to select the eligible subject to be enrolled into the study.

Method of data collection

This was by interviewing the mothers of U5 children selected for the study using questionnaire by the researcher and trained resident doctors.

Instrument of data collection

The instruments for data collection had a set of pretested interviewer- administered semi-structured questionnaire. The questionnaire contained the following sections:

Section A: Socio-demographic characteristics of the respondents.

Section B: Practice of Harmful traditional practice among the respondents, FGM, scarification marks, traditional uvulectomy, male traditional circumcision were the malpractices included in the questionnaire.

Data management

The data was analysed using SPSS version 22.

Ethical consideration

Ethical approval for this study was obtained from Sokoto state Ministry of Health Ethical Committee (SMH/1580/V.IV). Permission to carry out the study was sought from the respective LGA authorities and district heads of the communities. In addition, written informed consent was also obtained from the study participants.

Results

Majority 136(42.5%) and 234(73.1%) of the respondents were in the age group 25-34years and housewives respectively, there ages ranged from 20 to 49 years. The mean age of the mothers was 29.9± 8.3, and almost half (43.8) of the respondents had Qur'anic education (Table 1). Most of the respondents 244(76.2%) have five number of children and below respectively (Table 1).

Table 1: Socio-demographic characteristics of the respondents

Variables	Frequency (*n* = 320)	Percentage (%)
Mothers' age (years)		
15 – 24	90	28.1
25 – 34	136	42. 5
35 – 44	71	22.2
≥ 45	23	7.2
Tribe		
Hausa/Fulani	304	95.0
Yoruba	5	1.6
Igbo	1	0.3
Others	10	3.1
Religion		

Islam	315	98.4
Christianity	5	1.6
Educational level		
None	9	2.8
Qur'anic only	140	43.8
Primary	26	8.1
Secondary	75	23.4
Tertiary	70	21.9
Occupational status		
House wife	234	73.1
Civil Servant	62	19.4
Self Employed	11	3.4
Unemployed	7	2.2
Student	6	1.9
Parity		
1 -5	244	76.2
>5	76	23.8

Largest proportion 146(45.3%) the under –fives were in the age range 1-12 months, with a mean age of 22.5 ± 17.7 months. Of the under –five children, 199(62.2%) were males and 121(37.8%) were females, male to female ratio was 1.6:1 (Table 2).

Table 2: Demographic characteristics of the Under-five children

Variables	Frequency (*n* = 320)	Percentage (%)
Age (in months)		
<1	12	3.8
1-12	146	45.3
12-24	63	19.7
35-44	40	12.5
≥45	59	18.4
Sex		
Male	199	62.2
Female	121	37.8

Of the 320 mother, 80(25.0%) of their under five-year children were circumcised by traditional healers. Out of the 121 females, 35(28.9%) had female genital mutilation, and hymenectomy was the type of FGM performed for the children, while 11(3.4%) of the under-fives had scarification marks (Table 3).

Table 3: Type of Harmful Traditional Practice performed for the under-five children

Type of HTP	Frequency	Percentage (%)
Traditional circumcision	80.0	25.0
Traditional uvulectomy	189.0	59.1
Female Genital mutilation	35.0	28.9
Scarification marks	11	3.4

Table 4 show the common 29(83.0%) reason for the practice of FGM is to make it easy for the prospective husband to penetrate the wife during sexual intercourse, while most of the respondents reasons for the practice of traditional uvulectomy and scarification marks were due to tradition in 93(29.1%) and 8(54.1%) of the mothers respectively (Table 4).

Table 4: Reason for the practiced of Harmful Traditional Practice

Variable	Frequency	Percentage (%)
Reason for FGM (n=35)		
Tradition	4.0	11.4
To make it easy for the prospective husband to penetrate the wife during sexual intercourse	29.0	83.0
Do not know	2.0	5.7
Reason for traditional scarification marls (n=11)		
Tradition	6.0	54.5
Do not know	2.0	18.1
Prevent Failure to Thrive	3.0	27.3
Reason for traditional Uvulectomy (Multiple responses allowed)		
Recurrent vomiting	27.0	8.4
To treat throat infection	39.0	12.1
Chronic cough	13.0	4.1
Recurrent diarrhoea	9.0	2.8
Failure to thrive	33.0	10.3
To prevent throat infection	18.0	5.7
Tradition	93.0	29.1
Reason for traditional circumcision (n=80)		
Tradition	43.0	53.7
To prevent infection	19.0	23.8
Do not know	5.0	6.25
To prevent failure to thrive	7.0	8.8

Maternal level of education was the only factor associated with practice of Female Genital Mutilation, as the practice is more among the mothers of under-fives with neither formal or qur'anic education (p=0.008) Table 5.

Table 5: Factors Associated with practice of Female Genital Mutilation

Variable	Practice of FGM		Statistical test
	Yes n (%)	No n (%)	*p* value
Mothers age category			
15-24	13(44.8)	16(55.2)	
25-34	14(25.0)	42(75.0)	Fisher's exact 0.155
35-44	7(25.0)	21(75.0)	
45 and above	1(12.5)	7(87.5S)	
Occupation of Mother			
Civil servant	3(10.3)	26(89.7)	
Self employed	1(25.0)	3(75.0)	Fisher's exact 0.091
Student	1(50.0)	1(50.0)	
House wife	301(33.7)	541(64.3)	
Unemployed	0	21(100.0)	
Maternal level of education			
None	1(50.0)	1(50.0)	
Qur'anic	22(46.8)	23(0.0)	
Primary	2(16.7)	10(83.0)	Fisher's exact 0.008
Secondary	6(22.2)	21(77.8)	
Tertiary	4(12.1)	29(87.9)	
Religion			
Islam	35(29.4)	84(70.6)	Fisher's exact 0.661
Christianity	0(0.0)	1(100.0)	
Others	0(0.0)	1(100.0)	
Parity			
1 -5	28(30.8)	63(69.2)	0.607 0.436
>5	7(23.3)	23(76.7)	
Tribe			
Hausa	34(30.1)	79(69.9)	Fisher's exact 0.685
Yoruba	0	2(100.0)	
Igbo	0	1(100.0)	
Others	1(20.0)	4(80.0)	

The respondent's educational status (p=0.001) and age (p = 0.002) were factors associated with the practice of traditional circumcision.

Table 6: Factors Associated with practice of traditional circumcision

Variable	Practice of traditional circumcision		Statistical test
	Yes n (%)	No n (%)	*p* value
Mothers age category			
15-24	29(47.5)	32(52.5)	
25-34	24(30.0)	56(70.0)	Fisher's exact 0.002
35-44	15(34.9)	28(65.1)	
45 and above	12(80.0)	3(20.0)	
Occupation of Mother			
Civil servant	8(24.2)	25(75.0)	
Self employed	3(42.9)	4(57.1)	
Student	1(25.0)	3(75.0)	Fisher's exact 0.308
House wife	66(44.0)	84(56.0)	
Unemployed	**2**(40.0)	**3**(60.0)	
Maternal level of education			
None	0	7(100.0)	
Qur'anic	53(57.0)	40(43.0)	
Primary	8(57.1)	6(42.9)	Fisher's exact 0.0001
Secondary	10(20.8)	38(79.2)	
Tertiary	9(24.3)	28(75.7)	
Religion			
Islam	80(40.8)	116(59.2)	
Christianity	0	2(100.0)	Fisher's exact 0.358
Others	0	**1**(100.0)	
Parity			
1 -5	62(40.5)	91(59.5)	0.029 0.866
>5	18(39.1)	28(60.9)	

The respondent's educational status, religion and tribe (p <0.05) respectively were factors associated with the practice of traditional uvula cutting (Table 7).

Table 7: Factors Associated with practice of traditional uvulectomy

Variable	Practice of traditional uvulectomy		Statistical test
	Yes n (%)	No n (%)	*p* value
Mothers age category			
15-24	56(62.2)	34(37.8)	
25-34	81(59.6)	5540.4)	1.637 0.155
35-44	41(57.7)	30(42.3)	
45 and above	11(47.8)	12(52.2)	
Occupation of Mother			
Civil servant	20(32.9)	42(67.7)	
Self employed	3(27.3)	8(72.7)	
Student	4(66.7)	2(33.3)	Fisher's exact 0.001
House wife	159(67.9)	75(32.3)	
Unemployed	3(42.9)	4(57.1)	
Maternal level of education			
None	5(55.6)	4(44.4)	
Qur'anic	95(67.9)	45(32.1)	
Primary	17(65.4)	9(34.6)	Fishers exact 0.008
Secondary	44(58.6)	31(41.3)	
Tertiary	189(59.1)	131(40.1)	
Religion			
Islam	189(60.0)	126(40.0)	
Christianity	0	2(100.0)	Fishers exact 0.02
Others	0	2(100.0)	
Parity			
1-5	141(57.8)	103(42.2)	0.691 0.406
>5	48(63.2)	28(36.8)	

Discussion

The prevalence of FGM reported in our study was 28.9%, while Garba *et al* at Kano state Nigeria reported a very high (96.2%) prevalence of FGM among female infants, on the contrary, Gebrekirstos *et al* (2013) reported zero prevalence for the practiced of FGM when compared to the findings of this study, the zero prevalence of FGM in Gebrekirstos *et al* (2013) study was attributed to increase awareness of families on the complications of FGM such as HIV and others through improved health education by health personnel and via mass media. likewise, Jimoh *et al* (2018) [22] in rural Northern Nigeria reported a low prevalence of FGM of 0.4% among the newborns but a high prevalence of traditional uvulectomy of 42.7% among the neonates, while 4.1% of the newborns had traditional scarification marks. Another study also reported that majority (82.0%) of the FGM in their study was done before the age of five years, a period when these children can neither give informed consent nor understand why they are been cut (Epundu *et al*, 2018) [9]. The practice of FGM is high in Nigeria with one-quarters of the global estimates occurring in the country, and it cuts across all socio-cultural and geo-political zones in the country, with the highest prevalence among adult women (35%) found in the South East, followed by South West (30%) and lowest in the North East (6.0%) (Epundu *et al*, 2018) [9]. There is also report of high prevalence and generation trends of FGM in Malaysia, Indonesia, India, Oman, United Arab Emirate (UAE), Kenya, Djibouti, Sudan, Egypt, Somalia and Uganda suffers and Nigeria in large magnitude. FGM is still practice in Sokoto despite the huge complications associated with the practice (Epundu *et al*, 2018, Jimoh *et al* 2018) [9, 22]. this may be as a result of not implementing child right ACT and policies and laws prohibiting this act. The main reason for the practice of FGM in the majority of the respondents in this study is, if hymenectomy is not done for a girl child it will prevent her to stay in the husband house because she will experience difficulty during sexual intercourse, to prevent such from occurring, FGM is performed for the girl child as a preventive measure or if not done during childhood, it will be carried at the time of marriage in order to make it easy for the prospective husband to penetrate with ease during sexual intercourse.

Pertaining the practice traditional scarification, 3.4% of the children in this study had traditional scarification and the major reason for the practice was as a result of tradition, similarly, Beser *et al* (2010) [6] in Izmir, Turkey reported that a quarter of mothers had practiced traditional scarification

marks on the noses, backs of ears, backs or limbs of their children for treatment of jaundice.

This community based study showed persistence of harmful traditional practice, as more than half (59.1%) of the respondents in this study practiced traditional uvulectomy for their under-fives, and traditional uvulectomy was the commonest HTP among the children, this corroborates the findings of Alene *et al* (2002) [5] that reported a higher prevalence of 99.5% among their respondents when compared to our study, the prevalence (52.5%) of traditional uvulectomy reported by Yirdaw *et al* (2020) is lower than what reported in this study. In contrast to the findings of Fabian *et al* (2006) that reported association between level of education and tribe of respondents with the practice of traditional uvulectomy, significant association was reported in this study, this may be explained by the fact that the study respondents were predominantly Hausas by tribe with qur'anic education, Islamic religion is against HTPs among women and children, the practice of HTPs is purely based on tradition not religion. The Nigeria constitutions of 1960, 1963, 1979 and 1999 as amended in 2011 prohibit HTPs on children (Omoniyi, 2020) [13] S, despite this and several laws and policies it is worrisome that these HTPs are still practiced, the persistence of these harmful traditional practices shows that the laws are dormant.

Conclusion

Harmful traditional practices are still prevalent in Sokoto. Government at all levels should embark on awareness creation programs on the dangers of these harmful traditional practices through mass media, schools and religious places. Introducing the effects of HTPs into the school curricula especially at primary and secondary school levels, a target and continuous health education to mothers on HTPs, Involvement of traditional leaders in the campaign against HTPs in Sokoto, and the banning of harmful traditional practices are recommended.Child protection laws should be implemented to curtail these harmful practices.

Conflict of Interest

There is no conflict of interest among the authors in this study.

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